MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

06624

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Lothian

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Home - near Lothian

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Rural - Lothian

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Barkendale farm near Lothian

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Cora Austin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	W

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Nov. 1, 1902

8. AGE:

Years	Months	Days	If less than one day
44	5	9	____ hrs. ____ min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: William McClain

13. Birthplace: S. Carolina

MOTHER — 14. Maiden name: Minnie Gilmore

15. Birthplace: S. Carolina

16. Informant: Bernil L. Austin

Address: 5226 Ball Pl. S.E. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 14, 1947 (month) (day) (year)

Cemetery or crematory: Holly Grove

Location: Eagle Spring, N. Carolina

18. Funeral director: E. A. Hayden & Son

Address: Gahanville, Md.

19. April 14 1947 (Date rec'd by registrar) H. K. Clayton (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 1947, at 6:00 P M

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ ____ 19__ to 19__

and that I last saw h__ alive on 19__

Immediate cause of death	DURATION
Cardiorespiratory failure	
Due to: Pulmonary Impysema;	3
Due to: Bronchial pneumonia; Duration, Unknown.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: Not done

PHYSICIAN: Please underline the cause te which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Edward P. Ritchings, M.D. M. D. or other

Address: Annapolis, Md. Date signed: April 13, 1947

Acting M.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23d)

CERTIFICATE OF DEATH

00625

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: a e

City or town: annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Emergency Hospital

How long in hospital or Institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: maryland County: a e

City or town: Harness creek
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural Rte annapolis
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary T. Basil

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: arthur T. Basil

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Sept 1 1877

8. AGE:	Years	Months	Days	If less than one day
	67	7	7	...hrs. ...min.

9. Birthplace: annapolis md
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business:

FATHER
12. Name: John w cof
13. Birthplace: maryland

MOTHER
14. Maiden name: Emma watson
15. Birthplace: maryland

16. Informant: arthur T. Basil
Address: Harness Creek, annapolis R F D 3

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April (month) 10 (day) 47 (year)

Cemetery or crematory: St annes

Location: annapolis. Md

18. Funeral director: B. L. Hopkins & Son

Address: annapolis. md

19. April 16 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7 19 47, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 45 to April 19 47 and that I last saw h... alive on April 7 19 47

	DURATION
Immediate cause of death: Myocardial degeneration	2 h
Due to: Hypertension	2
Due to:	
Other conditions: Cardiac Sclerosis	unk

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Geneva Boyd M. D. or other

Address: annapolis md Date signed: 4-9-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

306

00626

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos. 8 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 4 mos. 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 405 Anne St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Pleasant Brown

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): ? 1885

8. AGE: Years	Months	Days	If less than one day
62?	?	?	---hrs. ...min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ---

FATHER — 12. Name: Dennis Brown

FATHER — 13. Birthplace: ?

MOTHER — 14. Maiden name: Susan ?

MOTHER — 15. Birthplace: ?

16. Informant: Hospital Records, Crownsville State Hospital, Crownsville, Maryland
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/14/47 (month) (day) (year)

Cemetery or crematory: Mt Calvery

Location: Brooklyn Md.

18. Funeral director: Elroy O. Wilson

Address: 1000 Brantly Ave

19. April 14 19 47 (Date rec'd by registrar) A. W. Medusk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 1947, at 4:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 2 1946 to April 10 1947 and that I last saw him alive on April 10 1947

Immediate cause of death: General Paresis — DURATION: Known to us since 12/2/46

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jack D. Hollingsworth M. D. or other

Address: Crownsville, Maryland Date signed: 4/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

OC627 9

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-46M

1. PLACE OF DEATH:
County A. A. Co Md
City or town Pasadena Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A. A Co., Md
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Pinkney Burley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	W

6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 75 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Prince George Co., Md (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Isaac Burley
13. Birthplace Md

MOTHER
14. Maiden name Unknown
15. Birthplace

16. Informant Emma Matthews
Address A. A. Co Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/4/47 (month) (day) (year)
Cemetery or crematory Mt Calvary Pt
Location A. A. Co. Md

18. Funeral director Isaiah E. Brown & Son
Address 108 W Montgomery St

19. May 2 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1947, at 11 50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 29th 1947, to April 29th 1947
and that I last saw him alive on April 29th 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	2 hours.
Due to Arteriosclerosis	unknown
Due to Chronic Interstitial Nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John [illegible] M. D. or other
Address [illegible] Date signed 5/1/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(463)

CC628

CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-[illegible]M

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 69 Prince George
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Daniel W. Burtis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Sarah Burtis
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 5th 1872

8. AGE: Years 74 | Months 9 | Days 16 | If less than one day ..... hrs. ..... min.

9. Birthplace Annapolis Md.
(Town, county, and state)

10. Usual occupation Waterman

11. Industry or business Fishing

MOTHER
12. Name Emily Holliday
13. Birthplace Annapolis Md.

FATHER
14. Maiden name William H. Burtis
15. Birthplace A. A. Co Md

16. Informant William H. Burtis
Address Eastport A A Co Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof April 24th 1947 (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis Md.

18. Funeral director John M. Taylor
Address Annapolis Md.

19. April 24 19 47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21, 1947, at 7 20 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 4-3- 1947, to 4-21- 1947
and that I last saw h[illegible] alive on 4-21- 1947

Immediate cause of death	DURATION
Broncho-Pneumonia	3 days
Due to: Carcinoma of Sigmoid	
Colon	2 yrs.
Due to: Cachexia	3 mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James R. Martin, M.D.
M. D. or other
Address 185 Prince George St Annapolis Md. Date signed 4/22/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00629

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs. 9 mos. 5 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 2 yrs. 9 mos. 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 703 Cumberlane Pl. (Alleghaney Pl.)
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: George Byrd

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Widowed

6.(b) Name of husband or wife: deceased
6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): ? 1899

8. AGE: Years	Months	Days	If less than one day
54 ?	--	--	-- hrs. -- min.

9. Birthplace: Salisbury
(Town, county, and state)

10. Usual occupation: Paint mixer

11. Industry or business: --

FATHER
12. Name: Henry Byrd (deceased)
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sallie Dixon (deceased)
15. Birthplace: Maryland

16. Informant: Hospital Records, Crownsville State
Address: Hospital, Crownsville, Maryland

17. Buried
(Burial, cremation, or removal. Which?)
Date thereof: 4-16-47
(month) (day) (year)

Cemetery or crematory: Hospital Cemetery

Location: Crownsville, Maryland

18. Funeral director: Supt.

Address: Crownsville

19. 4/16 1947
(Date rec'd by registrar)
E. Joyce Rose
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2 1947 at 4:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28 1935 to April 2 1947 and that I last saw him alive on April 2 1947

Immediate cause of death	DURATION
General Paresis	Known to us since 6/28/35
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wm. T. Stinebrook M. D. or other
Address: Date signed:

VS A15 9.46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1312)

00630

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3 Bacon St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Anne K. Carroll

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: James E. Carroll
6.(c) If alive, wife age years
7. Birth date of deceased (mo., day, yr.): Oct 28th 1907

8. AGE: Years 39 | Months 6 | Days | If less than one day: hrs. min.

9. Birthplace: Roanoke Va
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Rose Kessler
15. Birthplace: Va

18. Informant: James E. Carroll
Address: Annapolis Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Apr. 29th 1947
(month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md.
18. Funeral director: John M. Taylor Son
Address: Annapolis Md.

19. April 28 19 47
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 27, 1947 19 at 1-55A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/25/46 19 to 4/27/47 19 and that I last saw her alive on April 27, 1947 19

Immediate cause of death	DURATION
Multiple Sclerosis	3 yrs.
Due to	
Due to	
Other conditions Uremia due to Chronic Nephritis.	2 days

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Albert L. Anderson MD, M. D. or other
Address: Annapolis, Md. Date signed: 4-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164-D)

CERTIFICATE OF DEATH

60631

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: A. A.

City or town: South Haven

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

South Haven

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Washington D.C. County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1493 Irving St N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: Peter O. Coales

3.(b) Social Security Number: 216-07-4876

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 1 — 1907

8. AGE:

Years	Months	Days	If less than one day
40	2	10	hrs. min.

9. Birthplace: Virginia

(Town, county, and state)

10. Usual occupation: Cabinet maker

11. Industry or business:

FATHER

12. Name: John O. Coales

13. Birthplace: Va

MOTHER

14. Maiden name: Katherine Baldenson

15. Birthplace: Va

16. Informant: Katherine Coales

Address: 1493 Irving St N.W. Washington D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 22/47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington Va

18. Funeral director: D L Hopkins & Son

Address: Annapolis. Md

19. April 20, 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 19 1947, at M

21. I CERTIFY that death occurred on the date above stated: Post mortem Examination Apr. 19 1947

Immediate cause of death	DURATION
Due to: Suicide by	
Due to: Drowning	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: about 4/13/47

Where did injury occur? South Haven (City or town) D.C. (County) Md. (State)

Injured at home, farm, industry, public place (where?): South River

Means of injury: Drowning Injured at work? No

23. SIGNATURE: John M Cluff M.D Deputy Medical Examiner

M. D. or other

Address: Annapolis. Md Date signed: 4/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

V0632

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long above place of death? 3 hours

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1106 N. Monroe St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME William Colbert

3.(b) Social Security Number 216-14-7033

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	married

6.(b) Name of husband or wife: Dorothy

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 2, 1924

8. AGE: Years	Months	Days	If less than one day
22	8	7	hrs. min.

9. Birthplace: Salto, Md. (Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business

FATHER — 12. Name: John Colbert

FATHER — 13. Birthplace: Alabama

MOTHER — 14. Maiden name: Mattie Wallace

MOTHER — 15. Birthplace: Calvert Co. Md.

16. Informant: Mrs. Mattie Colbert

Address: 1106 Monroe St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 13, 1947 (month) (day) (year)

Cemetery or crematory: Family Lot

Location: Parkers Creek

18. Funeral director: Mrs. Lurge H. Holland

Address: 1631 Druid Hill Ave.

19. April 12 1947 (Date rec'd by registrar) A. V. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9 1947 at 11:30 P. M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Postmortem Examination 19

~~and that I last saw him alive on~~ Apr. 10 1947

Immediate cause of death	DURATION
Fracture of Skull	3½ hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 4-9-47

Where did injury occur? Near Gano (City or town) (County) (State)

Injured at home, farm, industry, public place, (where?) Route #301 near Route #50

Means of injury: Auto accident Injured at work? No

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner M. D. or other

Address: Annapolis, Md. Date signed: 4-10-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P

00633

Reg. Dist. No.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Anne Arundel.
City or town: Patapsco - P.O. Linthicum
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Same County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edward Albert Sexton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	S

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov-18-1946

8. AGE: Years: 0 | Months: 4 | Days: 15 | If less than one day: hrs. min.

9. Birthplace: Bon Secours Hosp. Baltimore, Md.
(Town, county, and state)

10. Usual occupation: none.

11. Industry or business:

FATHER
12. Name: Gerald Sexton
13. Birthplace: Philadelphia Pa.

MOTHER
14. Maiden name: Elizabeth G. Brown.
15. Birthplace: Baltimore, Md.

16. Informant: Gerald Sexton (father)
Address: Patapsco, P.O. Linthicum

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 5 1947 (month) (day) (year)
Cemetery or crematory: Moreland Memorial Park
Location: Taylor ave. Baltimore Md
18. Funeral director: S. Lester Earp
Address: 5523 Main St, Elkridge (27) Md.

19. Apr. 5 1947 (Date rec'd by registrar) A.W. Hedrick J.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April-3rd 1947, at 8:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Bronchio-Pneumonia	two days.
Due to: Enterocolitis	3 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gustave H. Faucher M.D.
acting Medical Examiner M. D. or other
Address: Glen Burnie Md. Date signed: 4/3/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16a)

00634

CERTIFICATE OF DEATH

Reg. Dist. No. 19 23

1. PLACE OF DEATH:

County Anne Arundel

City or town Linthicum

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

Old Tennmore Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Anne Arundel

City or town Linthicum

(If outside city or town limits, write RURAL and give nearest town)

Street No. Tennmore Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Donna Marie Dowling

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

B.(b) Name of husband or wife

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/29/47

8. AGE:

Years	Months	Days	If less than one day
		5	hrs. min.

9. Birthplace Tennmore Rd, Linthicum Md (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER

12. Name William Earl Dowling

13. Birthplace Baltimore, Md

MOTHER

14. Maiden name Florence Irene Porter

15. Birthplace Washington Md

16. Informant Mrs Wm E. Dowling (Mother) Address Linthicum Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 3, 1947 (month) (day) (year)

Cemetery or crematory Melvilla Cemetery

Location Elkridge Md

18. Funeral director A. Lester Earp

Address Elkridge Md

19. April 2 1947 (Date received by Registrar) (mise) E. Bird Wilkins Registrar

Catonsville Monmouth Road

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1947, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/29 1947, to 4/2 1947 and that I last saw h[illegible] alive on 4/1 1947

Immediate cause of death	DURATION
Atelectasis	5 days
Congenital	
Due to	
to acute pneumonia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B B Brumbaugh M. D. or other

Address Elkridge Md Date signed 4/2/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1244)

00635 P

CERTIFICATE OF DEATH

Reg. Diat. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 5M

1. PLACE OF DEATH:
County A. A. County
City or town Riviera Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Anne Arundel
City or town Riviera Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No. Carroll & Garden Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Millard F. Downey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

B.(b) Name of husband or wife Mary A. Downey
B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 7, 1890

8. AGE: Years	Months	Days	If less than one day
57	2		..... hrs. ..... min.

9. Birthplace Laurel, Md.
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business
MOTHER FATHER 12. Name Jesse A. Downey
13. Birthplace Laurel, Md.
MOTHER 14. Maiden name Mary Knapp
15. Birthplace Laurel Md.
16. Informant Mrs. Mary A. Downey
Address Carroll & Garden Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory Nuw Cathedral
Location Baltimore
18. Funeral director Fred. A. Cole
Address 1700 W. Lombard St. Balto.
19. April 15 19 47 (Date rec'd by registrar) A. W. Yeduck Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10th 19 47, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 19 47 to April 10 19 47
and that I last saw h..c..m alive on April 10 19 47

	DURATION
Immediate cause of death Cardiac Failure	15 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. Brady Smith, M.D.
M.D. or other
Address Riviera Beach, Md. Date signed 4/14/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00636

(135a)

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Harwood
(If outside city or town limits, write RURAL and give nearest town)

Street No. Harwood P.O.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William B. Elliott

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Sallie P. Elliott

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3rd 1863

8. AGE:

Years	Months	Days	If less than one day
83	7		hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Farmer and

11. Industry or business Judge of Orphans Court A.A.Co.

FATHER 12. Name Benjamin E. Elliott

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Anna Evens

MOTHER 15. Birthplace Maryland

16. Informant Miss Virginia Sears

Address Harwood Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 7th 1947 (month) (day) (year)

Cemetery or crematory Mt Zion Cemetery

Location Mt Zion A.A.Co. Md

18. Funeral director John M. Taylor Son

Address Annapolis Md.

19. April 7, 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-4 1947, at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10 1947, to April 4 1947.

and that I last saw h.. alive on April 3 1947.

Immediate cause of death hypostatic pneumonia — DURATION

Due to acute cystitis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emily A. Wilson M.D.
M. D. or other

Address Lothian Md. Date signed 4/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-43 50M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

OC637

Reg. Diat. No. 28

1. PLACE OF DEATH:
County Anne Arundel
City or town Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 yrs. 3 mos. 16 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 18 yrs. 3 mos. 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Snowhill (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
McKinley Ennalls

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife ?
6.(c) If alive, give age —— years
7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
50?	?	?	....hrs. ....min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business —

FATHER
12. Name Fred Ennalls
13. Birthplace ?

MOTHER
14. Maiden name ?
15. Birthplace ?

16. Informant Hospital Records, Crownsville State Hospital, Crownsville, Maryland
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 24/47 (month) (day) (year)
Cemetery or crematory Cemetery
Location Cambridge Md.
18. Funeral director Lewis H Blayneum
Address Cambridge, Md.,

19. April 23, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 19 47 at 6:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5 19 29 to April 21 19 47 and that I last saw h... im ...alive on April 21 19 47

Immediate cause of death Tuberculosis of the Lungs DURATION Known to us since 4-12-47
Due to
Due to
Other conditions Mental Deficiency with Psychosis Known to us since 1/5/29
(Include pregnancy within 3 months of death)
Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Crownsville, Maryland Date signed 4/21/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

00638

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 28

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45

1. PLACE OF DEATH:
County A. A.
City or town Conaway
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A. A.
City or town Conaway
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Henry Greenleaf

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	widower

6.(b) Name of husband or wife Martha Greenleaf 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24 1869

8. AGE: Years 77 Months Days If less than one day hrs. min.

9. Birthplace A. A. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Edward Greenleaf
13. Birthplace Md

MOTHER 14. Maiden name Bettie Thomas
15. Birthplace Md.

16. Informant Samuel Greenleaf
Address Gambrills P. O.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 22 1947 (month) (day) (year)
Cemetery or crematory Mt Tabor.
Location Chesterfield (Dorc.)

18. Funeral director J. B. Thomas
Address Annapolis

19. Apr 21 1947 (Date rec'd by registrar) E. F. Boyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1947 at 10.45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1947 to April 19 1947
and that I last saw him alive on April 15 1947

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to Arterio Sclerosis,	
Hemiplegia,	
Due to Hypertension marked	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE O'Meara M D
M. D. or other
Address Millersville Md Date signed 4/20/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00639

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: A. A.
City or town: Lambill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: A. A.
City or town: Lambill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Martha Greenleaf

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	Colored	Married

6.(b) Name of husband or wife: Henry Greenleaf
6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): 1876

8. AGE: Years 69 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: Lambills Md (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business
FATHER 12. Name: Joseph Thomas
13. Birthplace: Md
MOTHER 14. Maiden name: Mary Cuntoonn
15. Birthplace: Md.
16. Informant: Walter Greenleaf
Address: Lambill Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 13-47 (month) (day) (year)
Cemetery or crematory: Mt Taboh
Location: Chesterfield, Dist.
18. Funeral director: J B Johnson
Address: Annapolis
19. April 12 47 E. J. [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11 19 47 at 3.30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 10 19 46 to April 10 19 47
and that I last saw h[illegible] alive on April 10 19 47
Immediate cause of death: Coronary disease — DURATION: 4 mos
Due to: Chr valvular heart disease — 3 yrs
Due to: Arteria Sclerosis — 2 o
Due to:
Other conditions: Hypertension
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: O. H. MacNemar MD
M. D. or other
Address: Millersville Md Date signed: 4/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28 — 00648

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months 10 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 3 months 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: 800 Block Brunt Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Frank Hall

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife: ?

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): ? 1891

8. AGE: Years	Months	Days	If less than one day
56?	?	?	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: --

FATHER — 12. Name: Freddy ?

FATHER — 13. Birthplace: ?

MOTHER — 14. Maiden name: Alice ?

MOTHER — 15. Birthplace: ?

16. Informant: Hospital Records, Crownsville State Hospital, Crownsville, Maryland (Address)

17. Buried (Burial, cremation, or removal. Which?) Date thereof: 5/7/47 (month) (day) (year)

Cemetery or crematory: Hospital Cemetery

Location: Crownsville, Maryland

18. Funeral director: State Hospital

Address: Crownsville

19. May 7 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25 1947 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15 1947, to April 25 1947 and that I last saw h... in... alive on April 25 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Known to us since 1/15/47
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 4-25-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(97)

00641

Reg. Diat. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Marylande County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1203 Park Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Hall

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Widowed

6.(b) Name of husband or wife: ?deceased
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Unk 1861

8. AGE: Years	Months	Days	If less than one day
85 Unk.	?	?	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: —

FATHER
12. Name: William ?
13. Birthplace: ?

MOTHER
14. Maiden name: Lillian Chase
15. Birthplace: ?

16. Informant: Hospital Records, Crownsville State Hospital, Crownsville, Maryland
Address

17. buried (Burial, cremation, or removal. Which?) Date thereof April 26, 1947 (month) (day) (year)
Cemetery or crematory: Arubuts Memorial Park
Location: Baltimore, Maryland

18. Funeral director: Mrs. Francis A. Hemsley
Address: 578 West Biddle Street, Baltimore, Md.

19. Apr. 24 (Date rec'd by registrar) 1947 E. J. Joyce Registrar Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23 19 47 at 4:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31 19 47 to April 23 19 47 and that I last saw him alive on April 23 19 47

Immediate cause of death	DURATION
Generalized Arteriosclerosis	Known to us since 3/31/47
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Albert J. Bruckner M. D. or other
Address: Crownsville, Maryland Date signed: 4-24-47

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

(1) MARGIN RESERVED FOR BINDING

3504

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

5502 0064 2

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: A. A. County
City or town: Garland Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, Institution, or street address where death occurred:
.....
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: ~~Baltimore~~ Garland Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 102 Oak ave
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME: James W. ~~Hartley~~ Hartley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mary F. Hartley
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 1, 1872

8. AGE: Years	Months	Days	If less than one day
74	8		..... hrs. ..... min.

9. Birthplace: Martinsburg, W. Va. (Town, county, and state)
10. Usual occupation: machinist
11. Industry or business: Retired B. & O. R.R.
FATHER 12. Name: James W. Hartley
13. Birthplace: Berkley Co. W. Va.
MOTHER 14. Maiden name: Emelia Largent
15. Birthplace: Pa Pa, W. Va.
16. Informant: Mrs Mary F. Hartley
Address: 102 Oak ave Garland Park Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-14-47 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore
18. Funeral director: Frederick A. Cole
Address: 1700 W. Lombard St
19. April 10 1947 A. M. Yeuch (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 10 1947, at 7:20 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APRIL 3 1947, to APRIL 9 1947
and that I last saw h. l/m alive on APRIL 9 1947

Immediate cause of death	DURATION
CONGESTIVE HEART FAILURE	
Due to ARTERIOSCLEROSIS	
Due to SENILITY	
Other conditions TERMINAL UREMIA	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Henry F. Gregory M.D. M. D. or other
Address: 201 Annapolis Blvd. E. N. Date signed: 4/10/47
Glen Belmie 8 Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-46 M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

00643

28

Reg. Dist. No.

M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr 4 months 29 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 1 yr. 4 mos. 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Junction
(If outside city or town limits, write RURAL and give nearest town)
Street No. ---
(If rural, give LOCATION)
2.(a) If veteran, name war: -p-

3. (a) FULL NAME
John Thomas Hebron

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	~~Separated~~ Married

6.(b) Name of husband or wife: ?
6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1870

8. AGE: Years	Months	Days	If less than one day
76	?	?	--- hrs. --- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: ---

FATHER
12. Name: Steven Hebron
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Toiler
15. Birthplace: Maryland

16. Informant: Hospital Records, Crownsville State
Address: Hospital, Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof 4/17/47 (month) (day) (year)

Cemetery or crematory: Hospital Cemetery

Location: Crownsville, Maryland

18. Funeral director: Supt. Hospital
Address: Crownsville Md

19. 4/17/47 (Date rec'd by registrar) E. Joyce Lucas Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14 1947 at 12:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 16 1945 to April 14 1947 and that I last saw him alive on April 14 1947

Immediate cause of death	DURATION
Chronic Myocarditis	Known to us since 11-16-45
Due to	
Due to	
Other conditions: Senile Psychosis - simple deterioration (Include pregnancy within 3 months of death)	Known to us since 11-16-45

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert V. Hinegardner M. D. or other
Address: Crownsville, Maryland Date signed: 4/14/47

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30 b 30 b

CERTIFICATE OF DEATH

00644 P

BC Reg. Dist. No. 28

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr 10 mos. 10 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 1 yr. 10 mos. 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 410 North Spring St.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Boyd Horton

3.(b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Mildred Horton

6.(c) If alive, give age: ?

7. Birth date of deceased (mo., day, yr.): 1918

8. AGE: Years	Months	Days	If less than one day
28	?	?	hrs. min.

9. Birthplace: South Carolina
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ---

FATHER 12. Name: Davis Horton (deceased)

FATHER 13. Birthplace: South Carolina

MOTHER 14. Maiden name: Minnie Railey

MOTHER 15. Birthplace: South Carolina

16. Informant: Hospital Records, Crownsville State Hospital

Address: Hospital, Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/13/47 (month) (day) (year)

Cemetery or crematory: Hawkins Chapel

Location: Franklinton N. C.

18. Funeral director: Elroy A. Wilson

Address: 1000 Brantley Ave Huntington N.C.

19. (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 1947 at 4:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31 1945 to April 10 1947 and that I last saw him alive on April 10 1947

Immediate cause of death: General Paresis — DURATION: Known to us since 5/35/45

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert V. Whitehead M. D. or other

Address: Date signed:

00645

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52)

CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County a a
City or town annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County a a
City or town St Margarets
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Clarence T. Hughes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Rose E Hughes
6.(c) If alive, give age 77 years
7. Birth date of deceased (mo., day, yr.) Sept 5 – 1866

8. AGE: Years	Months	Days	If less than one day
80	7	5	hrs. min.

9. Birthplace Moscow (Town, county, and state)
10. Usual occupation Engineer
11. Industry or business
FATHER 12. Name Theodore Hughes
FATHER 13. Birthplace Moscow Ohio
MOTHER 14. Maiden name Mrs Shelby
MOTHER 15. Birthplace Ohio
16. Informant Mrs Rose E Hughes
Address St Margarets Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 22-47 (month) (day) (year)
Cemetery or crematory Glen Haven
Location Glen Burnie
18. Funeral director B-L Hopkins & Son
Address Annapolis Maryland
19. April 21 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 19 47 at 7 p M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 47 to April 20 19 47 and that I last saw h. alive on April 20 19 47

Immediate cause of death	DURATION
Uremia	4 days
Due to Chr Nephritis	3 Yrs
Due to Carcinoma Bladder	3 yrs
Other conditions Arteriosclerosis	unkn

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George C Bond M. D. or other
Address Annapolis Md Date signed 4.21.47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (936)

CERTIFICATE OF DEATH

0C646

Reg. Diat. No. 28

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 yrs. 8 mos. 18 days

Hospital, Institution, or street address where death occurred: Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 19 yrs. 8 mos. 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Colesville (If outside city or town limits, write RURAL and give nearest town)

Street No. ---

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Thomas Jackson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Emma Jackson

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 1880

8. AGE: Years	Months	Days	If less than one day
66	?	?	...hrs. ...min.

9. Birthplace: ? (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: ?

FATHER — 13. Birthplace: ?

MOTHER — 14. Maiden name: ?

MOTHER — 15. Birthplace: ?

16. Informant: Hospital Records, Crownsville State Hospital, Crownsville, Maryland

Address:

17. Buried (Burial, cremation, or removal. Which?) Date thereof April 17, 1947 (month) (day) (year)

Cemetery or crematory: Colesville Cemetery

Location: Colesville, Maryland

18. Funeral director: Robert L. Snowden

Address: Rockville, Maryland

19. Apr 14 (Date rec'd by registrar) 1947 E. F. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13 19 47, at 7:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 19 27, to April 13 19 47

and that I last saw him alive on April 13 19 47

	DURATION
Immediate cause of death: Chronic Myocarditis	Known to us since 3/21/47
Due to: General Arteriosclerosis	Known to us about 5 years
Due to:	
Other conditions: Alcoholic Psychosis	Known to us since 7/27/27

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert L. Snowden M. D. or other

Address: Crownsville, Maryland Date signed 4/14/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00648

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month 9 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 month 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harry Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): ?

8. AGE: Years	Months	Days	If less than one day
73?	?	?	...hrs. ...min.

9. Birthplace: ? (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: —

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Hospital Records, Crownsville State
Address: Hospital, Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 4/25/47 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md
18. Funeral director: State Hospital
Address: Crownsville Md

19. Apr 25 1947 (Date rec'd by registrar) E T Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21 1947, at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 1947, to April 21 1947
and that I last saw him alive on April 21 1947

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us
	Mardh 12,47
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed 4-22-47

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

00648

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Eastport Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred:

608 Second St. Eastport Md.

How long in hospital or institution? ********** ****

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 608 Second St. Eastport

(If rural, give LOCATION)

2.(a) If veteran, name war: **********

3. (a) FULL NAME: Mary Elizabeth Johnson

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

6.(b) Name of husband or wife: Henry Johnson

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 5, 1877

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
70	I	I8		

9. Birthplace: Annapolis Md. A. A. Co. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER — 12. Name: Henry Marshall

FATHER — 13. Birthplace: Calvert Co. Md.

MOTHER — 14. Maiden name: Mateldia Cromwell

MOTHER — 15. Birthplace: Annapolis Md.

16. Informant: Henry Johnson

Address: 608 Second St. Eastport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/4/47 (month) (day) (year)

Cemetery or crematory: Brew Hill Cemetery

Location: West St. Extd. Annapolis Md.

18. Funeral director: Mrs Chas. E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. 5-4 (Date rec'd by registrar) 1947 — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30, 1947, at 10:P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Apoplexy	15 days
Due to: Hypertensive Cardio-Vascular Disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: T. E. Johnson Jr. M. D. or other

Address: 40 Northwest Street Date signed 4/3/47

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00649

1246

Reg. Dist. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Weeks

Hospital, institution, or street address where death occurred:
Station Hospital

How long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Arkansas County: Lonoke

City or town: Cabot
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....
(If rural, give LOCATION)

2.(a) If veteran, name war: - - -

3. (a) FULL NAME: ROME G. JORDAN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: ....

6.(c) If alive, give age .... years

7. Birth date of deceased (mo., day, yr.): September 30, 1879

8. AGE: Years	Months	Days	If less than one day
67	6	1	.... hrs. .... min.

9. Birthplace: Lonoke, Lonoke County, Arkansas
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: ....

FATHER 12. Name: John A. Jordan

FATHER 13. Birthplace: Pulaski County, Cabot, Arkansas

MOTHER 14. Maiden name: Sarah King

MOTHER 15. Birthplace: Arkansas

16. Informant: 1st Sergeant Clinton Nagel

Address: Fort George G. Meade, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof: April 2, 1947 (month) (day) (year)

Cemetery or crematory: Cabot, Arkansas

Location: ....

18. Funeral director: Dewitt Donaldson

Address: Laurel, Maryland

19. 2 April 19 47 (Date rec'd by registrar) BERNARD F. NEIMIN, Capt, MC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 April 19 47 at 10:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 Mar 19 47 to 1 April 19 47 and that I last saw him alive on 1 April 19 47

Immediate cause of death	DURATION
Pneumonia	2 days
Due to: Organism not determined	
Due to: Cirrhosis Liver	1 year
Other conditions: Arteriosclerotic Heart Disease	1 year
Cerebral Thrombosis	4 days

(Include pregnancy within 3 months of death)

Major findings of operation: .... Date of op. ....

Autopsy results: None performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE: John B Benson Capt MC M. D. or other

Address: Sta. Hosp., Ft. G. G. Meade, Md. Date signed: 7 Apr 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1821)

CERTIFICATE OF DEATH

00650

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, Institution, or street address where death occurred: 5-9 Clay St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: A.A.

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No.: 5-9 Clay St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Claud Kennedy

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	S

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 11, 1947

8. AGE:

Years	Months	Days	If less than one day
0	1	26	..... hrs. ..... min.

9. Birthplace: Annapolis A.A. Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Claud Kennedy

FATHER 13. Birthplace: Alabama

MOTHER 14. Maiden name: Alice Parker

MOTHER 15. Birthplace: Harwood, Md.

16. Informant: Alice Parker

Address: 5-9 Clay St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 8, 1947 (month) (day) (year)

Cemetery or crematory: Bruce Hill

Location: West St. Extended

18. Funeral director: Mrs. Lelas E. Hicks

Address: 43-45 Northwest St.

19. April 7, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6, 1947 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ..... 19..... to ..... 19.....

~~And that I last saw him~~ ..... alive on ..... 19.....

Immediate cause of death	DURATION
Cardiorespiratory failure	
Due to: Asphyxia	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Apr. 6, 1947

Where did injury occur? Annapolis (City or town) A.A. (County) Md. (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Suffocation Injured at work?

23. SIGNATURE: Edward P. Ritchie, Jr., M.D. attdg M.E. (M. D. or other)

Address: Annapolis, Md. Date signed: Apr. 6, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (70)

00651

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, Institution, or street address where death occurred: U. S. Naval Hospital
How long in hospital or institution? dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Illinois County: Cook
City or town: Chicago
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7114 S. Wolcott
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: George Edward Kopp

3.(b) Social Security Number: 345-20-4825

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 18, 1927

8. AGE:

Years	Months	Days	If less than one day
19	5	3	hrs. min.

9. Birthplace: Chicago, Ill. (Town, county, and state)
10. Usual occupation: A.E.R.M. 3C, U.S.N.
11. Industry or business: U.S.N.

FATHER
12. Name: WILLIAM KOPP
13. Birthplace: Unknown

MOTHER
14. Maiden name: HELENA ANNA CIATOR
15. Birthplace: Unknown

16. Informant: U.S. Navy Records
Address: Annapolis, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: April 25/47 (month) (day) (year)
Cemetery or crematory:
Location: Chicago Ill.
18. Funeral director: B E Hopkins & Son
Address: annapolis, md
19. April 25 19 47 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21 19 47 at 2 20 M

21. I CERTIFY that death occurred on the date above stated: ~~What disease caused this death~~
Post mortem Examination
~~Antecedent causes: Morbid conditions, if any, giving rise to the above cause, stating the underlying cause last~~ Apr. 21, 19 47

Immediate cause of death	DURATION
Crushed Skull	
Due to: Accidental	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 4-21-47
Where did injury occur? Annapolis (City or town) A.A. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Route # 2
Means of injury: Overturned auto Injured at work? no

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 4-21-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

66652

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A.A

City or town West Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Years

Hospital, institution, or street address where death occurred:

107 Randall St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town West Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 Randall
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Edward [illegible]--Lehmyer

3.(b) Social Security Number 216-05-1197

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Barbara B. Lehmyer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 17 1887

8. AGE: Years	Months	Days	If less than one day
59	9	2	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Paper Bailer

11. Industry or business

FATHER 12. Name Geo Lehmyer

FATHER 13. Birthplace Balto, Md.

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace Unknown

16. Informant Mrs Mary M. Greentree

Address 107 Randall St. West Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 22 1947 (month) (day) (year)

Cemetery or crematory New Cathedral

Location Batimore, Md.

18. Funeral director B. L. Hopping & Son

Address Annapolis, Md.

19. April 21 19 47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19, 1947, at 5:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10, 1947, to April 19 1947

and that I last saw h[illegible] alive on 4-14 1947

Immediate cause of death	DURATION
Pulmonary Edema	4 days
Due to Chronic Myocarditis	2 yrs.
Due to Hypertensive Cardio-Vascular disease	4 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE James R. Martin, M.D. M. D. or other

Address 185 Prince George St Annapolis, Md. Date signed 4-21-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

Both a death

MARYLAND STATE DEPARTMENT OF HEALTH (159) 00653

CERTIFICATE OF ~~STILLBIRTH~~

Reg. Dist. No. 21

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County A. A. Co.

City or town Browns Woods
(If outside city or town limits, write RURAL and give nearest town)

Street address, hospital, or institution:
Annapolis R.F.D # 2

Length of mother's stay in County 24 yrs.
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Md.

County A. A. Co.

City or town Browns Woods
(If outside city or town limits, write RURAL and give nearest town)

Street No. Annapolis R.D.D # 2
(If RURAL give LOCATION)

3. Name of child James Little Jr.

4. Date of birth April 10 1947 Hour ..... M.

5. Sex Male | 6. Twin or triplet .....

7. No. of weeks pregnancy 34 wks.

FATHER OF CHILD

8. Full name James C. Little

9. Color col 10. Age at time of this birth 24 yrs.

11. Usual occupation Labor

MOTHER OF CHILD

12. Full maiden name Burnetta Cromwell

13. Color col 14. Age at time of this birth 24 yrs.

15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? .....
(b) How many other children were born alive but are now dead? ..... (c) How many other children were *born* dead? .....

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of None

19. Labor: (a) Complications of .....
(b) Induced? .....

20. (a) Was there an operation for delivery? No
(Yes or No)
(b) State all operations, if any —
(c) Did child die before operation? —
During operation? —

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
(a) Fetal causes Prematurity
(b) Maternal causes Syphilis

22. I certify to the birth of this child who was born ~~dead~~* alive on the date and hour above stated. ~~a~~ died within 30 mts.
Signature Ruth Thomas
(Specify if M. D., midwife, or other)
Address R.F.D. 1 Box 10 B Annapolis

23. (a) Burial (b) Date thereof Apr. 10, 1947
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory Broadneck

24. (a) Funeral director James C. Little (Father)
(b) Address St. Margarets, Md.

25. (a) April 10, 1947 (b) W. J. Trench
(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
W. J. Trench Health Officer, per. BBK

* See Instruction C on stub.

V. S. A10

Official line 30 mts

00654

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (930)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 Years
Hospital, institution, or street address where death occurred:
22 Washington Street
How long in hospital or institution? ----------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 22 Washington Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ----------

3.(a) FULL NAME: Charles Matthews

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Febuary 4, 1888

8. AGE: Years	Months	Days	If less than one day
59	2	10	..... hrs. ..... min.

9. Birthplace: Annapolis, Maryland
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: None
FATHER 12. Name: Bill Matthews
FATHER 13. Birthplace: Anne Arundel Co. Maryland
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: Unknown
16. Informant: Minerva Brown
Address: 22 Washington Street
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/ 16/ 1947 (month) (day) (year)
Cemetery or crematory: Brewer Hill Cemetery
Location: West Street Extended
18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street
19. April 14 1947 (Date rec'd by registrar) W. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13, 1947 at 9:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 46, to April 13, 1947
and that I last saw h. alive on April 13, 1947

Immediate cause of death	DURATION
Coronary thrombosis	4 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: -
Accident, suicide, or homicide ..... Date of .....
Where did Injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... , injured at work?

23. SIGNATURE: R. F. Richardson M.D. M. D. or other
Address: 110 Cleveland Annapolis Date signed 4/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00655

92d CB

Reg. Dist. No. 22

1. PLACE OF DEATH:

County: Anne Arundel

City or town: JESSUPS

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two months & 7 days

Hospital, institution, or street address where death occurred:

Maryland House of Correction

How long in hospital or institution? eleven days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: North Carolina County:

City or town: Wade

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME

Henry M. McAllister

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Single

6.(b) Name of husband or wife: - - - - -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 15, 1897

8. AGE:

Years	Months	Days	If less than one day
50	---	17	hrs. min.

9. Birthplace: WADE, N. C.

(Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: - - - -

FATHER

12. Name: Jesse McAllister

13. Birthplace: not known

MOTHER

14. Maiden name: Janie - -?

15. Birthplace: not known

16. Informant: M.H.C.

Address: Jessups, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 6, 1947 (month) (day) (year)

Cemetery or crematory: Fayetteville, N.C.

Location:

18. Funeral director: John M. Johnson

Address: 1700 Druid Hill Ave. Balt. 17, Md.

19. Apr 5 1947 (Date rec'd by registrar) Clara Karlick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1, 1947, at 4:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21 1947, to Apr. 1, 1947 and that I last saw him alive on March 31 1947

Immediate cause of death	DURATION
cerebral hemorrhage	3 days
Due to arteriosclerosis and chronic valvular heart disease	Years
Due to	
Other conditions Paralysis rt. face, right upper & lower extremities.	3 days

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - - - - Date of:

Where did injury occur? - - - - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John A. Clark, M.D. M. D. or other

Address: Jessups, Md. Date signed: Apr. 1, '47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00656

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 5M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 45 Southgate Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lottie E. Mc Nelly

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Leroy Mc Nelly

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 26th 1879

8. AGE: Years: 67 | Months: 10 | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Phila Pa (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER

12. Name: Unknown

13. Birthplace: Unknown

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: John E. Mc Nelly

Address: 45 Southgate Ave Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 28. 1947 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md.

18. Funeral director: John M. Taylor Son

Address: Annapolis Md.

19. April 28 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 1947 at 1.50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23, 1947, to April 26 1947 and that I last saw h... alive on April 26 1947

	DURATION
Immediate cause of death: Arteriosclerotic - Cardio Vascular Disease (Self explanatory)	2 yrs.
Due to:	
Due to:	
Other conditions: Chronic Nephritis Terminal Bronchitis - (Include pregnancy within 3 months of death)	2 yrs. 2 days

Major findings of operations: None

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert L. Anderson M.D. M. D. or other

Address: Annapolis, Md. Date signed 4/26/47


RECEIVED
APR 29 1947
BURI

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00723

(183)

Reg. Dist. No. 21

FILE NO. G 109 APR 29 1947

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? nine (9) months
Hospital, institution, or street address where death occurred:
Severn River at Naval Academy
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: W. Virginia County: Wyoming
City or town: Eccles, West Virginia
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MERRIWEATHER, OTIS (nmn)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 7-17-26

8. AGE: Years	Months	Days	If less than one day
20 ~~19~~	8	29	..... hrs. ..... min.

9. Birthplace: Winding Gulf, Wyoming, W.Va. (Town, county, and state)
10. Usual occupation: U.S. Navy
11. Industry or business: None

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden name: VIRGINIA SIMMONS
15. Birthplace: Unknown

16. Informant: Naval Hospital Records
Address: Annapolis, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: April 19, 1947 (month) (day) (year)
Cemetery or crematory:
Location: Beckley, West Virginia. Raleigh Co.

18. Funeral director: B.L. Hopping & Son
Address: Annapolis, Maryland.

19. April 19 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION (4/10/47)

20. DATE OF DEATH: Unknown - approx 19 ..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....
and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Drowning -	
Due to	
Due to	
Other conditions: None (Include pregnancy within 3 months of death)	

Major findings of operations: None
Date of op.
Autopsy results: evidence of drowning
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: Unknown
Where did injury occur? USNA - Annapolis, Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Unknown
Means of injury Injured at work?

23. SIGNATURE: T.B. McNamara M. D. or other
Address: USN Annapolis, Md. Date signed: 4/18/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

00657

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Edgewater
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, Institution, or street address where death occurred:
Home - Woodland Beach

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Rural Edgewater
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Highland Drive Woodland Beach
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: Oscar Norfolk

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mrs. Lula Jessie Norfolk

6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): Aug. 25, 1904

8. AGE: Years: 42 Months: 7 Days: 13 If less than one day: ____ hrs. ____ min.

9. Birthplace: Calvert Co., Md.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: "

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: "
15. Birthplace: "

16. Informant: Mrs. Jessie Norfolk
Address: Woodland Beach

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 9 1947 (month) (day) (year)

Cemetery or crematory: Arlington Cem.

Location: Arlington Va

18. Funeral director: W. E. Sheldon

Address: Annapolis, Md.

19. Apr 7 1947 (Date rec'd by registrar) W. H. Clayton Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 7 19 47, at 5-00 A. M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ____ 19__, to 19__

~~and that I last saw h~~ alive on 19__

Immediate cause of death	DURATION
Coronary thrombosis	1 hr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Edward P. Ritchie, M.D.
M. D. or other
acting M. E.

Address: Annapolis, Md. Date signed: Apr. 7, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45 15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95d

CERTIFICATE OF DEATH

00658

Reg. Dist. No. 20

1. PLACE OF DEATH:

County A.A.

City or town Davidsonville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? I8 Months

Hospital, institution, or street address where death occurred:

Davidsonville,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County A.A.

City or town Davidsonville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Darthula Oaks

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife William R. Oaks 6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) April 4 I876

8. AGE: Years	Months	Days	If less than one day
7I		I2	hrs. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden name Jane Martin

15. Birthplace Virgina

16. Informant William R. Oaks

Address Davidsonville, Md.

17. ~~Burial~~ Removed (Burial, cremation, or removal. Which?) Date thereof I7 April I947 (month) (day) (year)

Cemetery or crematory Unknown

Location Rose Hill, Virgina, Lee County

18. Funeral director B.L.Hopping & Son

Address Annapolis, Md.

19. April 17 I947 (Date rec'd by registrar) Carrie Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1947, at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10 1947, to April 16 1947

and that I last saw h alive on March 1 1947

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to hypertension ?	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emily H. Wilson, M.D. M. D. or other

Address Lothian Md. Date signed 4/17/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00659

Reg. Dist. No. 26

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Churchton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Churchton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Dorcas Offer
3.(b) Social Security Number: none

4. Sex: F
5. Color or race: Col
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: John Offer
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Oct 15, 1874

8. AGE: Years: 72 Months: 5 Days: 22 If less than one day: hrs. min.

9. Birthplace: Churchton Md (Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business:
FATHER 12. Name: Geo. Shaw
13. Birthplace: Churchton
MOTHER 14. Maiden name: Elizabeth Lizzy
15. Birthplace: Churchton
16. Informant: Dairy Thompson
Address: Churchton
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 10 1947 (month) (day) (year)
Cemetery or crematory: Franklin Camp
Location: Churchton Md
18. Funeral director: V. E. Standiford & Son
Address: Gabriells Md.
19. April 9 1947 (Date rec'd by registrar) D B Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7th 1947, at 10:08 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar 5th 1947, to April 7 1947
and that I last saw her alive on April 7 1947
Immediate cause of death: Chronic Myocarditis — DURATION: 1½ yrs
Due to:
Due to:
Other conditions: Arterio Sclerosis — DURATION: 1½ yrs
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. P. Richardson M.D. M. D. or other
Address: 118 Clay St, Annapolis Md. Date signed: 4/8/47

VS A15 9-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

00660

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-46 5M

1. PLACE OF DEATH:
County. ANNE ARUNDEL
City or town. ANNAPOLIS
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? UPON ARRIVAL
Hospital, institution, or street address where death occurred:
U. S NAVAL HOSPITAL ANNAPOLIS MD
How long in hospital or institution? DEAD UPON ARRIVAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ANNE ARUNDEL
City or town ANNAPOLIS
(If outside city or town limits, write RURAL and give nearest town)
Street No. 37 WEST
(If rural, give LOCATION)
2.(a) If veteran, name war. MEXICAN - WORLD WAR-1-2

3. (a) FULL NAME JOHN DIAZ PASTRANA

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MRS JULIA MIRO PASTRANA
6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) JUNE 24. 1888

8. AGE:

Years	Months	Days	If less than one day
58	9	26	..... hrs. ..... min.

9. Birthplace SAN JUAN, PUERTO RICO
(Town, county, and state)
10. Usual occupation BAND MASTER - U.S. NAVY
11. Industry or business RETIRED
FATHER 12. Name JUAN PASTRANA
13. Birthplace PUERTO RICO
MOTHER 14. Maiden name RAMONA DIAZ
15. Birthplace PUERTO RICO
16. Informant MRS JULIA M. PASTRANA (WIFE)
Address 37 WEST ST. ANNAPOLIS MD
17. BURIAL Date thereof APR. 22 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory NATIONAL
Location ANNAPOLIS MD
18. Funeral director JOHN M. TAYLOR + SON
Address ANNAPOLIS MD.
19. April 22, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1947 at 5.15 P.M.
21. I CERTIFY that death occurred on the date above stated: the [redacted]
Post mortem Examination
and that [redacted] April 19 1947

	DURATION
Immediate cause of death	
Due to Coronary occlusion	sudden
Due to Coronary Sclerosis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroat causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE John M. Clapp M.D. Deputy Medical Examiner
M. D. or other
Address Annapolis, Md Date signed 4-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (451)

CERTIFICATE OF DEATH

00661

Reg. Dist. No. 26

1. PLACE OF DEATH:
County A A
City or town Millersville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County A A
City or town Millersville (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war 1st World War.

3.(a) FULL NAME Marion Lutch Perry
3.(b) Social Security Number

4. Sex M
5. Color or race W
6.(a) Single, married, widowed, or divorced ~~W~~ Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Aug 12, 1891
8. AGE: Years 55 Months 7 Days 25 If less than one day ... hrs. ... min.
9. Birthplace Md (Town, county, and state)
10. Usual occupation Painter
11. Industry or business Painting
FATHER 12. Name Oliver H Perry
13. Birthplace Md
MOTHER 14. Maiden name Sarah Welch
15. Birthplace Md
16. Informant Allen Perry
Address Millersville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 8-1947 (month) (day) (year)
Cemetery or crematory St James
Location Odenton
18. Funeral director [illegible] Hardesty Funeral Home
Address Gaithersville Md
19 April 7 19 46 (Date rec'd by registrar) J. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/6 19 47 at 5 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ..., to ... 19 ...
and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Carcinoma of throat	3 yrs
Due to (Hosp care of Dr Kemble, Balt Md)	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings of operations ... Date of op. ...
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE H Ward M. D. or other
Address Owings Md Date signed 4/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46 B)

CERTIFICATE OF DEATH

Reg. Dist. No. 006626

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Deale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 MONTHS
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A.A.
City or town: Deale, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3. (a) FULL NAME: MARY EMILY Proctor

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: CHARLES A.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): MAY 29 1872

8. AGE: Years	Months	Days	If less than one day
75	0	7	..... hrs. ..... min.

9. Birthplace: Sunderland 99. Co Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: William Welch
13. Birthplace: Cal. Co. Md.
MOTHER 14. Maiden name: Frances Trott
15. Birthplace: Cal. Co. Md.
16. Informant: Mrs Bryson Wood
Address: Deale Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 9. 1947 (month) (day) (year)
Cemetery or crematory: St James Epis
Location: Deale Md
18. Funeral director: C. A. Saudenty & Son
Address: Galesville Md
19. April 7 1947 (Date rec'd by registrar) D. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 - 6 19 47 at 4:50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1946, to April 6 1947 and that I last saw h[illegible]alive on April 6 1947

Immediate cause of death	DURATION
Carcinoma, cardiac end of stomach	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Emil H. Nielsen M. D. or other
Address: Lutheran Date signed 4/7/47.

AGE: Doctor's statement and affidavit of informant filmed G109 4-29-47 LL(Filed under PUMPHREY 4-29-47)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94-a

CERTIFICATE OF DEATH

Reg. Dist. No. 6666 33

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years.
Hospital, institution, or street address where death occurred: 308 Crain Highway N.W.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
Street No. 308 Crain Highway N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: William John Pumphrey

3. (b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Married.

6.(b) Name of husband or wife: Ella Stone
6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): May 20 - 1876

8. AGE: Years	Months	Days	If less than one day
70	11	25	hrs. min.

9. Birthplace: Millersville (Town, county, and state)
10. Usual occupation: Farmer (Retired)
11. Industry or business:

FATHER
12. Name: Thomas O. Pumphrey
13. Birthplace: Millersville, Md.

MOTHER
14. Maiden name: Rachel Steen
15. Birthplace: Philadelphia, Md. Pa.

16. Informant: Mrs Leonard Darley (daughter)
Address: Glen Burnie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 17, 1947 (month) (day) (year)
Cemetery or crematory: Baldwin Memorial
Location: Millersville, Md.

18. Funeral director: Thomas W Singleton
Address: Glen Burnie, Md.

19. April 16 1947 (Date rec'd by registrar) M. E. Alba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14 1947, at 4.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__
and that I last saw h__ alive on ____ 19__

Immediate cause of death	DURATION
Coronary Occlusion	sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Gustave H. Faulenbach M.D.
(Attending physician, coroner, medical examiner, M.D. or other)
Address: Glen Burnie Md. Date signed 4/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

Reg. Dist. No. 00604 2-1

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Brownswoods
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Louis Stanford Robinson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	S.

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19th 1947

8. AGE: Years | Months 2 | Days | If less than one day hrs. min.

9. Birthplace Annapolis Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Leland Stanford Robinson
13. Birthplace Maine

MOTHER 14. Maiden name Flora Cantlen
15. Birthplace A A Co Md.

16. Informant Mrs Leland S. Robinson
Address Brownswoods A A Co Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 20th 1947 (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis Md.

18. Funeral director John M. Taylor Son
Address Annapolis Md

19. April 18 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18th 1947, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-16- 1947, to 4-18 1947
and that I last saw h... alive on 4-17-47 19...

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Albert L. Cohen M.D. M. D. or other
Address Annapolis Md Date signed 4-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 5M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(B) 0665

Reg. Dist. No. 23

1. PLACE OF DEATH:
County A. A.
City or town Linthicum
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs
Hospital, Institution, or street address where death occurred:
Heath Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County Same
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Arthur Franklin Sachse — SOCHSE — SAWCLISE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W	widower

6.(b) Name of husband or wife Emilia Sachse

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 17 1854 ?

8. AGE: Years 93 | Months 7 | Days 12 | If less than one day ... hrs. ... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual occupation Stationary Engineer

11. Industry or business

FATHER
12. Name Edward Sachse
13. Birthplace Germany

MOTHER
14. Maiden name
15. Birthplace

16. Interment Linthicum Cemetery
Address Heath Ave Linthicum

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/5/47 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Richie Highway

18. Funeral director Edward Fontaine

Address 1359 Wash Blvd

19. April 3 1947 (Date rec'd by registrar) A. W. Bedwell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1947, at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan — 1940, to April 3 1947 and that I last saw h... alive on April 3 1947

Immediate cause of death	DURATION
Cardio Vascular renal disease	3 weeks
Due to	
Due to	
Other conditions Arterio sclerosis	20 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Sachse Jr. M.D.
M. D. or other

Address Linthicum Date signed 4-3-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-0

CERTIFICATE OF DEATH

00666

Reg. Diat. No. 23

1. PLACE OF DEATH:

County a. a.

City or town Linthicum

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 yr.

Hospital, institution, or street address where death occurred: Archwood Blvd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A.

City or town Linthicum

(If outside city or town limits, write RURAL and give nearest town)

Street No. Archwood Blvd.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME Charles August Schemm

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Mable Schemm

6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Feb. 5 - 1875

8. AGE: Years 72 | Months 2 | Days 10 | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual occupation Retired - R.R. Conductor

11. Industry or business R.R. B-O

MOTHER FATHER

12. Name John Schemm

13. Birthplace Germany

14. Maiden name Annie ? -

15. Birthplace Germany

16. Informant Mable Louise Schemm

Address Linthicum Heights

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4 | 15 | 47. (month) (day) (year)

Cemetery or crematory Grace Church Cemetery

Location Elbridge, Maryland

18. Funeral director Easton Sons

Address Ellicott City, Md.

19. 4/14 1947 A. W. Dennis Jr. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1947, at 5:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 1938 to April 15 1947 and that I last saw him alive on April 15 1947

Immediate cause of death	DURATION
Cardiac Vascular Disease	8 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Ball Jr. M.D. M. D. or other

Address Linthicum Date signed 4-12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

CERTIFICATE OF DEATH

D0667

Reg. Dist. No. 25

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Brooklyn Park —
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 yrs —
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Anne Arundel
City or town: Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5202 Gov. Ritchie Highway
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME John Schneider

3.(b) Social Security Number —

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Catherine Schneider
6.(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): Sept 10 1855
8. AGE: Years 91 Months 7 Days — If less than one day ... hrs. ... min.
9. Birthplace: Baltimore, Md (Town, county, and state)
10. Usual occupation: At Home —
11. Industry or business: —
12. Name of father: Don't Know —
13. Birthplace of father:
14. Maiden name of mother: Christina ?
15. Birthplace of mother: ? , ?
16. Informant: Mrs. Anna Muelhause (Daughter)
Address: 5202 Gov. Ritchie Hgy - 9.9.6 md
17. Burial — (Burial, cremation, or removal. Which?) Date thereof: Apr. 14, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cem.
Location: A. A. Co. Md.
18. Funeral director: R. Howard Evans
Address: 1400 E. Chase St Balto 30 Md
19. April 12 1947 (Date rec'd by registrar) A. W. Hedrick, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10, 1947 2:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 8 1947 to April 10 1947 and that I last saw h— alive on April 9 1947

Immediate cause of death	DURATION
Coronary Embolism	20 min
Mitral Regurgitation	9 do
Due to Aortic Stenosis	3d
Hypertension	3d
Due to Arteriosclerotic Nephritis	3d
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: I. F. A. Stevens M.D.
M. D. or other
Address: 7818 Hanford Rd Date signed: 4-11 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 5M

Birth and Death

MARYLAND STATE DEPARTMENT OF HEALTH (200c) 06668

CERTIFICATE OF ~~STILLBIRTH~~

Reg. Dist. No. 24

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County a a

City or town annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street address, hospital, or institution: Emergency Hospital

Length of mother's stay in County 23 days

(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland

County a a

City or town Annapolis, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 72 Southgate Ave

(If RURAL give LOCATION)

3. Name of child Stillborn Small Boy

4. Date of birth April 4 1947 Hour 4 P M.

5. Sex F | 6. Twin or triplet | 7. No. of weeks pregnancy

FATHER OF CHILD

8. Full name James F Smael

9. Color W 10. Age at time of this birth 31 yrs.

11. Usual occupation Engineer

MOTHER OF CHILD

12. Full maiden name Katherine S. Doe

13. Color W 14. Age at time of this birth 25 yrs.

15. Usual occupation House wife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 1

(b) How many other children were born alive but are now dead? ..... (c) How many other children were *born* dead? .....

17. Did child die before labor? ..... During labor? .....

18. Pregnancy, complications of .....

19. Labor: (a) Complications of .....

(b) Induced? .....

20. (a) Was there an operation for delivery? ..... (Yes or No)

(b) State all operations, if any .....

(c) Did child die before operation? .....

During operation? .....

21. **Cause of stillbirth.** Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Unknown

(b) Maternal causes Unknown

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature Albert H. Anderson MD

(Specify if M. D., midwife or other)

Address Annapolis, Md

23. (a) Burial (b) Date thereof April 5 1947

(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory St. Anne's

24. (a) Funeral director H. C. Hopkins & Son

(b) Address Annapolis, Md.

25. (a) April 5 1947 (b) [signature]

(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.

..... Health Officer, per .....

* See Instruction C on stub.

Issued 4/5/47

Child lived 25 minutes.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10?)

00669

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County Anne Arundel
City or town Severn (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEACTED:
(For newborn infants give residence of mother)
State Md. County Anne Arundel
City or town Severn (If outside city or town limits, write RURAL and give nearest town)
Street No. Camp Meade Rd (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lewis Reese Springer
3.(b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Widower
6.(b) Name of husband or wife Lena E. Springer
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) December 18, 1866

8. AGE: Years 80 | Months 4 | Days 4 | If less than one day ..... hrs. ..... min.

9. Birthplace St. Marys County, Md. (Town, county, and state)
10. Usual occupation Retired
11. Industry or business
FATHER 12. Name Unknown
13. Birthplace
MOTHER 14. Maiden name Unknown
15. Birthplace
16. Informant L Rex Springer
Address 1718 Gwynns Rd., Baltimore
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-26-47 (month) (day) (year)
Cemetery or crematory Cathedral
Location Baltimore
18. Funeral director George A Farley
Address Fulton Ave. & Fayette St.
19. April 24 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 - 1947 at 7. P M
24. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22-47 to April 22-47
and that I last saw him alive on April 22-47
Immediate cause of death Acute Cardiac Failure — DURATION 1 day
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M.D. or other
Address Severn Md Date signed April 22-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46a (46a)

00670

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Entire life

Hospital, Institution, or street address where death occurred:
U.S.Naval Hospital, Annapolis, Maryland.

How long in hospital or institution? Two (2) days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 23 Southgate Ave., Annapolis, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Robert Ellis STRANGE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 15, 1879

8. AGE:	Years	Months	Days	If less than one day
	67	11	14	..... hrs. ..... min.

9. Birthplace Annapolis, Anne Arundel, Maryland
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name John STRANGE
13. Birthplace North Carolina

MOTHER
14. Maiden name Amanda TERRY
15. Birthplace Annapolis, Maryland

16. Informant R.Adm. H. E. STRANGE, USN(Ret).

Address 23 Southgate Ave., Annapolis, Md.

17. Removal Date thereof April 30 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Johnstown, Pennsylvania.

18. Funeral director R.L.Hopping & Son

Address Annapolis, Maryland.

19. April 30, 1947 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1947, at 3:30 A.M. EDT

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1946, to April 29 1947 and that I last saw him alive on April 28, 1947

Immediate cause of death CARCINOMA OF ESOPHAGUS — DURATION 9 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results Carcinoma of esophagus

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Thomas W. Green

23. SIGNATURE Thomas W. Green, LTJG MC USNR.
M. D. or other

Address U.S.Naval Hospital, Annapolis, Maryland Date signed 4-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00671 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Ann Aundell

City or town: Annapolis, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months

Hospital, institution, or street address where death occurred: USNH, Annapolis, Maryland

How long in hospital or institution? 5 Months

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 3100 Belmont Avenue (If rural, give LOCATION)

2.(a) If veteran, name war: I

3.(a) FULL NAME: George (n) SUGARMAN

3.(b) Social Security Number: ----- 217-05-2834

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Anna Sugarman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 2, 1896

8. AGE: Years	Months	Days	If less than one day
50	8	3	hrs. min.

9. Birthplace: New York, New York (Town, county, and state)

10. Usual occupation: Retired- CPO U. S. Navy

11. Industry or business: Retired

FATHER 12. Name: none

13. Birthplace:

MOTHER 14. Maiden name: none

15. Birthplace:

16. Informant: Hospital Records

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4/9/47 (month) (day) (year)

Cemetery or crematory: Arlington National Cem.

Location: Arlington, Va.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 4-7-47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 April 19 47, at 2255 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-26 19 46, to 4-5 19 47 and that I last saw him alive on 4-5-47 19

Immediate cause of death: Heart Failure	DURATION
Due to: Chronic Myocarditis	
Due to: Coronary Thrombosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: none Date of op.:

Autopsy results: Substantion of above Diagnosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: D.G. Doane D.G. DOANE, LTJG, MC, USNR M. D. or other

Address: USNH, ANNAPOLIS, MD. Date signed: 4-6-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-E)

00672

CERTIFICATE OF DEATH

Reg. Dist. No. 27

FILE NO. G 110 JUN 20 1947

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One Day
Hospital, institution, or street address where death occurred:
Station Hospital
How long in hospital or institution? One Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 463 Delaware Ave., S. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I ✓

3. (a) FULL NAME: RICHARD TAYLOR

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	NEGRO	SINGLE

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): DECEMBER 25, 1890

8. AGE: Years	Months	Days	If less than one day
56	3	15	hrs. min.

9. Birthplace: Easton, North Carolina (Town, county, and state)
10. Usual occupation: Fireman (Boat)
11. Industry or business

FATHER
12. Name: Daniel Taylor
13. Birthplace: Tyer, N. C.

MOTHER
14. Maiden name: Mary Ann Holley
15. Birthplace: Tyer, N. C.

16. Informant: George Cofield
Address: 463 Delaware Ave., S.W., Washington, DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-15-47 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Virginia

18. Funeral director: John T. Rhines & Co.
Address: 901-3rd St. S.W. Washington, D.C.

19. 10 April 19 47 (Date rec'd by registrar) BERNARD F. KEAVIN, Capt., Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 10 1947, at 4:10 P M

21. I CERTIFY that death occurred on the date above stated; ~~that I last attended deceased on~~ Post-mortem examination, to April 11 1947 ~~and that I last saw deceased on~~ 19

	DURATION
Immediate cause of death: Pending until autopsy report is completed.	
Due to: Chronic mitral endocarditis;	
Due to: Cardiac hypertrophy;	
Due to: Chronic hyperplastic pyelonephritis, R. & L.	
Due to:	
Other conditions: Generalized arteriosclerosis.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Pending
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John M. Coffey, M.D. Deputy Medical Examiner
M. D. or Other
Address: Annapolis, Md. Date signed: 4-11-47

PC

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

109A

00673

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:
County: Anne Arundel County.
City or town: Jessups, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. & 2 months.
Hospital, institution, or street address where death occurred:
Md. House of Correction.
How long in ~~hospital~~ or institution? 1 Yr. & 2 months.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Elkridge, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: ---
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME
WILLIAM TURNER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	Widowed.

6.(b) Name of husband or wife: Not known
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Ocotober 2, 1905.

8. AGE: Years	Months	Days	If less than one day
41	5	19	..... hrs. ..... min.

9. Birthplace: Howard County, Md.
(Town, county, and state)
10. Usual occupation: Laborer.
11. Industry or business: ---

FATHER
12. Name: Not known
13. Birthplace: ---

MOTHER
14. Maiden name: ---
15. Birthplace: ---

16. Informant: M.H.C.
Address: Jessup Md

17. Burial, cremation, or removal. Which? Burial
Date thereof: 4-24-47 (month) (day) (year)
Cemetery or crematory: Asbury.
Location: Howard Co

18. Funeral director: J.C. Hegenbothom
Address: Ellicott City Md

19. (Date rec'd by registrar) Apr 21 1947
Registrar: Clara Hoelich

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 21, 1947. 19..... at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 16th 1947 to Apr. 21st 1947
and that I last saw him alive on Apr. 20th. 1947.

Immediate cause of death	DURATION
Edema of Lungs.	12 hrs.
Due to: Virus pneumonia.	5 days.
Due to:	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: none - - - - - - - - -
Date of op. .....
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: none
Accident, suicide, or homicide: ..... Date of: -----
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: John A Clark M.D.
M. D. or other
Address: Md., House Correction. Date signed: 4-21-47.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

T

MAY - 1 1947

00674

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. 20

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Cumberstone
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Cumberstone
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Jane Ward.

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	negro	Widowed

6.(b) Name of husband or wife: Charles Ward
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 8 1869

8. AGE: Years	Months	Days	If less than one day
78	1	6	..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: Jake Warner
13. Birthplace: Va.

MOTHER
14. Maiden name: Margaret Banks
15. Birthplace: Va.

16. Informant: Florence Randall
Address: Cumberstone

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 17, 1947 (month) (day) (year)
Cemetery or crematory: Galesville cemtery
Location: Galesville

18. Funeral director: T. A. Hardesty & Son
Address: Galesville md.

19. Apr 17 1947 (Date rec'd by registrar) W. R. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14 1947 at 8 01 P.M

21. I CERTIFY that death occurred on the date above stated: ~~[illegible]~~ Post-mortem Examination ~~[illegible]~~ April 14 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Arterio-sclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

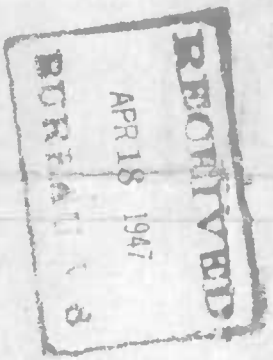
Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work? Deputy Medical Examiner

23. SIGNATURE: John M. Coffey M.D. M. D. or other
Address: Annapolis Md. Date signed 4-14-47



VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. [redacted]

1. PLACE OF DEATH:
County: Anne Arundel
City or town: X Laurel, Md (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yr 2 M 22 d
Hospital, institution, or street address where death occurred: District Training School
How long in hospital or institution? Same

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
47 x-3
State: [redacted] County: [redacted]
City or town: Wash. D C (If outside city or town limits, write RURAL and give nearest town)
Street No.: 115-2 - 21st NW (If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Chas. Warren

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	S

6.(b) Name of husband or wife: —
6.(c) If alive, give age: ____ years
7. Birth date of deceased (mo., day, yr.): Dec 17 - 28

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
18	4	3		

9. Birthplace: Wash - DC (Town, county, and state)
10. Usual occupation: —
11. Industry or business: —
12. FATHER — Name: Chas Warren
13. Birthplace: ?
14. MOTHER — Maiden name: Dorothy [illegible]
15. Birthplace: Virginia
16. Informant: Notary of D.T.S.
Address
17. Removal (Burial, cremation, or removal. Which?) Date thereof: 4-23-47 (month) (day) (year)
Cemetery or crematory
Location
18. Funeral director: Ambrose B Boyd
Address: 1238 20th st NW
19. Apr 21 1947 (Date rec'd by Registrar) 5-11 JSL Elaine Laibich (Registrar)

MEDICAL CERTIFICATION

20. DATE OF BIRTH: Apr 20 1947 (5-45)
21. I HEREBY that death occurred on the date above stated, that I attended deceased from 1-28 1947 to 4-20 1947 and that I last saw h[illegible] alive on 4-20-47
Immediate cause of death: Epilepsy
Due to: 353.3
Due to:
Other conditions: Mental Deficiency - Idiot 18 yr & Epilepsy
(Include pregnancy within 3 months of death)
Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, pub'c place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Rothrock MD (M. D. or other)
Address: Laurel Md Date signed: 4-30-47

5/11/55

LL

Pls put on file, apparently this is ~~the~~ the original certificate since it bears Clara Haslup's signature + Dr's signature.

[signature]

MAY 11 Rec'd

DVR+S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21 — RC 110675

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:
134 Lake Drive Bay Ridge

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: ~~3023 Eudowan Ave. Baltimore~~
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3023 Eudowan Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Henry Weidner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Edna Weidner

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): Aug. 19, 1901

8. AGE: Years	Months	Days	If less than one day
45	7	24	...hrs. ...min.

9. Birthplace: Baltimore, Md
(Town, county, and state)

10. Usual occupation: Pipefitter

11. Industry or business:

FATHER — 12. Name: Frederick Weidner
13. Birthplace: Germany

MOTHER — 14. Maiden name: Julianna Reichert
15. Birthplace: Germany

16. Informant: William A. Weidner
Address: 911 N. Belnord St Balto Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 16 1947 (month) (day) (year)

Cemetery or crematory: Baltimore Cemetery

Location: Baltimore Md.

18. Funeral director: Wm J. Tickner Sons Co

Address: Baltimore Md.

19. April 13 1947 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13 1947, at 1301 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ...19..., to ...19...

and ~~that I last saw him~~ alive on ...19...

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Edward P. Ritchie, M.D.
M. D. or other
Acting M.E.

Address: Annapolis, Md. Date signed: April 13 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00676

CERTIFICATE OF DEATH

Reg. Diat. No. 212

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 36 N. Glenn Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Henry Elmer Westervelt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Thelma Westervelt
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 18th 1884

8. AGE:	Years	Months	Days	If less than one day
	62	5	15	hrs. min.

9. Birthplace: Hackensack N.J.
(Town, county, and state)
10. Usual occupation: Road Construction
11. Industry or business:
FATHER 12. Name: William Westervelt
13. Birthplace: Nyack N.Y.
MOTHER 14. Maiden name: Frances A. Johnson
15. Birthplace: Haverstraw N.Y.
16. Informant: Mrs Thelma Westervelt
Address: 36 N. Glenn Ave Annapolis Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 5th 1947 (month) (day) (year)
Cemetery or crematory: Glen Haven Memorial
Location: Glen Burnie A & G Co Md
18. Funeral director: John M. Taylor Son
Address: Annapolis Md.
19. April 2 1947 (Date rec'd by registrar) Wm. Lynch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-2 1947 at 10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26 1947 to April 2 1947 and that I last saw h.. alive on April 2 1947

Immediate cause of death	DURATION
Paralytic Ileus	4 days
Generalized Peritonitis	10 days
Due to: Ruptured appendix	12 days
Due to:	
Other conditions: Bronchial asthma	Several years
Bronchiectasis	Several years

(Include pregnancy within 3 months of death)

Major findings of operations: Ruptured Gangrenous Appendix with Abscess & peritonitis - localized
Date of op. 3-24-47
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: George C Beal M. D. or other
Address: Annapolis Md Date signed: 4-2-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

Reg. Dist. No. 28 — 00677

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: ?
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JOHN WILLIAMS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	?

6.(b) Name of husband or wife: ?
? 6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): ? 1887

8. AGE: Years	Months	Days	If less than one day
60 ??	?	?	hrs. min.

9. Birthplace: ? (Town, county, and state)
10. Usual occupation: ?
11. Industry or business: ?

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Hospital Records, Crownsville State Hospital, Crownsville, Maryland
Address

17. Buried (Burial, cremation, or removal. Which?) Date thereof 5-7-47 (month) (day) (year)
Cemetery or crematory: Hospital Cemetery
Location: Crownsville, Maryland

18. Funeral director: Supt. Hospital Crownsville
Address

19. May 7 1947 (Date rec'd by registrar) E T Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29 1947, at 12:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 1947 to April 29 1947
and that I last saw him alive on April 29 1947

Immediate cause of death: Generalized and Cerebral Arteriosclerosis — DURATION: Known to us since April 19, 1947

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D., or other
Address: Crownsville, Maryland Date signed: 4-29-47

VS A15- 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47d)

U0678

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County A. A.

City or town Pasadena
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 mos.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A A.

City or town Pasadena
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME EMELIA V. WOODEN

3.(b) Social Security Number ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f.	white	widow

6.(b) Name of husband or wife Arthur E. Wooden

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1872

8. AGE: Years	Months	Days	If less than one day
75	2	7	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER 12. Name Linde

13. Birthplace Germany

MOTHER 14. Maiden name Marie Albrecht

15. Birthplace Germany

16. Informant Mrs. Edna Wolle

Address Pasadena, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-16-47 (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location A. A. Co., Md.

18. Funeral director Wm. Cook, Inc.

Address 1217 St. Paul st.

19. 4-15 1947 (Date rec'd by registrar) L. A. Blair Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1947 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25 1939 to April 13 1947 and that I last saw her alive on April 12 1947

Immediate cause of death	DURATION
Decompensated valvular heart disease (mitral & aortic)	? yrs.
Due to	
Due to	
Other conditions Probable malignancy of left lung (Include pregnancy within 3 months of death)	1 year

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. A. Blair M. D.
M. D. or other

Address Pasadena Md. Date signed 4-13-47

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00679

CERTIFICATE OF DEATH

Reg. Dist. No. 21 0

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 yrs
Hospital, institution, or street address where death occurred:
177 West Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 177 West Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: WOODWARD: James X

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary C. Woodward
6.(c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): Jan. 26, 1860

8. AGE: Years	Months	Days	If less than one day
87	2	7	...hrs. ...min.

9. Birthplace: Annapolis, Maryland
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business
FATHER 12. Name: James D. Woodward
13. Birthplace: Maryland
MOTHER 14. Maiden name: Jane Johnson
15. Birthplace: Annapolis, Maryland
16. Informant: Mrs Mary C. Woodward
Address: 177 West St. Annapolis, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-4-47 (month) (day) (year)
Cemetery or crematory: St Anne's Cemetery
Location: Annapolis, Maryland
18. Funeral director: Ben L. Hopping & Son
Address: 170-172 West St. Annapolis, Maryland
19. April 3 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2, 1947 19... at 6:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1947, to Apr. 2 1947
and that I last saw h.. M... alive on Apr. 2 1947

Immediate cause of death	DURATION
Cardiac sclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Ewood, Md. Date signed: Apr 2/1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9/45

1-35

Dr Lenhardt

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

CERTIFICATE OF DEATH

00680

Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Glen Burnie, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Main Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ALEXANDER A. YOCKEL.

3.(b) Social Security Number: 218-09-3876

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elva E. Yockel (Nee Virgin)
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): December 31, 1887

8. AGE: Years	Months	Days	If less than one day
59	3	1	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Pipe fitter
11. Industry or business: Speddens, Baltimore, Md.

FATHER
12. Name: Augustus A. Yockel
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Sophia A. Wilkins
15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Elva E. Yockel
Address: Glen Burnie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 4, 47 (month) (day) (year)
Cemetery or crematory: Western
Location: Baltimore, Md.
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.
19. 4/4 (Date rec'd by registrar) 19 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1, 19 47, at 3.00 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug- 19 46, to April 1 19 47
and that I last saw him alive on April 1 19 47

Immediate cause of death	DURATION
Anaplastic Carcinoma	8 mos.
of mediastinum + carried	
Due to glands -	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Chas. L. Boerner, M.D. M. D. or other
Address: Linthicum Heights, Md. Date signed:

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15